## Kitchen Staff Health Declaration Form

Position  Date  Health Screening Do you have any of the following symptoms? Fever Cough Sore Throat Nausea/Vomiting Diarrhea None of the above  Have you been diagnosed with or been in contact with any infectious diseases in the past 14 days?  Any cuts, wounds, or skin infections on hands or arms?
Date  Health Screening  Do you have any of the following symptoms?  Fever  Cough  Nausea/Vomiting  Diarrhea  None of the above  Have you been diagnosed with or been in contact with any infectious diseases in the past 14 days?
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Fever Cough Sore Throat Nausea/Vomiting Diarrhea None of the above Have you been diagnosed with or been in contact with any infectious diseases in the past 14 days?  Any cuts, wounds, or skin infections on hands or arms?
Cough Sore Throat Nausea/Vomiting Diarrhea None of the above Have you been diagnosed with or been in contact with any infectious diseases in the past 14 days?  Any cuts, wounds, or skin infections on hands or arms?
Sore Throat  Nausea/Vomiting  Diarrhea  None of the above  Have you been diagnosed with or been in contact with any infectious diseases in the past 14 days?  Any cuts, wounds, or skin infections on hands or arms?
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Diarrhea  None of the above  Have you been diagnosed with or been in contact with any infectious diseases in the past 14 days?  Any cuts, wounds, or skin infections on hands or arms?
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Additional Comments
I declare that the above information is true and accurate to the best of my knowledge. Signature